**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235-1720

**Respondent Name**
TWIN CITY FIRE INSURANCE COMPANY

**Carrier's Austin Representative Box**
Box Number 47

**MFDR Tracking Number**
M4-12-2032-01

**MFDR Date Received**
February 13, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Pine Creek Medical center was paid a total of $16,721.30 however our facility was under paid for CPT code 62362 per the APC Rate at 130%."

**Amount in Dispute:** $11,920.65

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Based on the policy governing device intensive procedures the carrier has made payment for the service portion of the APC multiplied by 200% with an additional payment of the device cost pursuant to Texas Guidelines."

**Response Submitted by:** The Hartford, 300 S. State Street, Syracuse, New York 13202

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 12, 2011 | Outpatient Hospital Services | $11,920.65 | $11,920.65 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT. FOR QUESTIONS REGARDING THIS ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. THIS SERVICE IS RE-PRICED ACCORDING TO THE TX PHYSICIAN FEE SCHEDULE.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. MAR AMOUNT IS GREATER THAN THE CHARGED AS PER TEXAS HOSPITAL GUIDELINES.
   - 181 – PAYMENT ADJUSTED BECAUSE THIS PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE. THE PROCEDURE CODE IS NOT REIMBURSABLE FOR OUTPATIENT SERVICES PER RULE 134.403(D).
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SVC/PX THAT HAS ALREADY ADJUDICATED. PAYMENT INCLUDED IN APC RATE PER THE TX HOSPITAL MEDICARE METHODOLOGY PER RULE 134.403(D).
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. REIMBURSEMENT FOR YOUR NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO STATE FEE GUIDELINES OR RULES AND REGULATIONS.
   - 173 – SERVICE WAS NOT PRESCRIBED BY A PHYSICIAN. DIRECT ADMISSION TO OBSERVATION IS REIMBURSED AFTER BEING SEEN BY A COMMUNITY PHYSICIAN PER RULE 134.403(D).

**Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

**Findings**

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $53,200.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code C1772 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.

- Procedure code 81003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.16. 125% of this amount is $3.95. The recommended payment is $3.95.
- Procedure code 85007 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.84. 125% of this amount is $6.05. The recommended payment is $6.05.
- Procedure code 99199 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for other procedures billed on the same claim. The use of a modifier is not appropriate. Separate reimbursement is not recommended.
- Procedure code 62362 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0227, which, per OPPS Addendum A, has a payment rate of $13,305.14. This amount multiplied by 60% yields an unadjusted labor-related amount of $7,983.08. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $7,756.36. The non-labor related portion is 40% of the APC rate or $5,322.06. The sum of the labor and non-labor related amounts is $13,078.42. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.206. This ratio multiplied by the billed charge of $10,738.50 yields a cost of $2,212.13. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $13,078.42 divided by the sum of all APC payments is 95.39%. The sum of all packaged costs is $831.21. The allocated portion of packaged costs is $792.90. This amount added to the service cost yields a total cost of $3,005.03. The cost of this service exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service is $13,078.42. This amount multiplied by 200% yields a MAR of $26,156.84.
- Procedure code 94640 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0077, which, per OPPS Addendum A, has a payment rate of $28.73. This amount multiplied by 60% yields an unadjusted labor-related amount of $17.24. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $16.75. The non-labor related portion is 40% of the APC rate or $11.49. The sum of the labor and non-labor related amounts is $28.24 multiplied by 12 units is $338.88. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $338.88. This amount multiplied by 200% yields a MAR of $677.76.
- Procedure code 94010 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0368, which, per OPPS Addendum A, has a payment rate of $59.63. This amount multiplied by 60% yields an unadjusted labor-related amount of $35.78. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $34.76. The non-labor related portion is 40% of the APC rate or $23.85. The sum of the labor and non-labor related amounts is $58.61 multiplied by 5 units is $293.05. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $293.05. This amount multiplied by 200% yields a MAR of $586.10.

- Procedure code Q9966 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
   - "IMP MEDT PUMP SYNCHROMED II" as identified in the itemized statement and labeled on the invoice as "PUMP 8637-20SM220ML EMANUAL US ONLY" with a cost per unit of $10,640.00.

   The total net invoice amount (exclusive of rebates and discounts) is $10,640.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,000.00. The total recommended reimbursement amount for the implantable items is $11,640.00.
5. The total allowable reimbursement for the services in dispute is $39,074.45. The amount previously paid by the insurance carrier is $16,721.30. The requestor is seeking additional reimbursement in the amount of $11,920.65. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $11,920.65.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $11,920.65, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Grayson Richardson | December 7, 2012 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.